STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM (Continued) | LIMITATIONS |
|---|---|
| 7.b. Home Health aid services provided by a home health agency<br><br>See Page 9-2 | d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 month of the date on which eligibility was determined.<br><br>3. Care rendered by local health agencies to patients in categories 04 and 40 is not reimbursable. |
| Services that require preauthorization | 1. Services provided by out-of-state agencies must be preauthorized or reimbursed on individual determination.<br><br>2. Services that exceed 12 visits per recipient per calendar month must be preauthorized. |

STATE PLAN FOR MEDICAL ASSISTANCE
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STATE OF MARYLAND

| PROGRAM (Continued) | LIMITATIONS |
|---|---|
| 7. Home Health Services - General<br><br>Skilled nursing serv. home health aide services, physical therapy serv., occupational therapy services, speech pathology services and medical supplies.<br><br>See Page 9-2 | 2. Preauthorization is required for any service or combination of services rendered during any 30 day period for which the provider anticipates interim payments from the program in excess of $1300.<br><br>3. Billing time limitations:<br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.<br><br>c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.<br><br>d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. |

N No. 91-16
Supersedes
TN No. 86-3

Approval Date _____

Effective Date JAN 28 1991

| PROGRAM | LIMITATIONS |
|---|---|
| a. Skilled nursing, home health aide, physical therapy, occupational therapy and speech pathology services. | 1. Preauthorization is required for more than one visit per type of service per day. |
| | 2. Non-skilled services are not covered. |
| | 3. Preauthorization is required for four or more hours of care per day whether the four hours are reached in one visit or in several visits in one day. |
| b. Home health aide services | 1. Bi-weekly supervisory visits by a registered nurse in the recipient's home must be made, every second visit of which shall include observations of the delivery of services by the aide to the recipient. |
| | 2. Services primarily for the purpose of housekeeping are not covered. |
| | 3. Services rendered to recipients with chronic conditions when those recipients require only personal care services are not covered. |
| c. Medical supplies, equipment and appliances suitable for use in the home | 1. The Program covers medical supplies subject to the limitations of the Disposable Medical Supply/Durable Medical Equipment Program and other supplies which are used during a covered home health visit as part of the treatment ordered by the recipient's attending physician. |
| | 2. Only functionally adequate models of equipment are authorized. Luxury models can not be purchased under normal operations. Medical equipment is subject to limitations of the Disposable Medical Supply/Durable Medical Equipment Program. |

STATE PLAN FOR MEDICAL ASSISTANCE
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| PROGRAM (Continued) | LIMITATIONS |
|---|---|
| 7. Home Health Services - General<br><br>Skilled nursing serv. home health aide services, physical therapy serv., occupational therapy services, speech pathology services and medical supplies. | 3. Care rendered by local health agencies to patients in categories 04 and 40 is not reimbursable. |
| Services that require Preauthorization | 1. Services provided by out-of-state agencies must be preauthorized or reimbursed on individual determination.<br><br>2. Physical therapy services that exceed 8 visits per recipient per calendar month, occupational therapy services that exceed 4 visits per recipient per calendar month, and speech pathology services that exceed 8 visits per recipient per calendar month must be preauthorized.<br><br>3. Services and medical supplies that cost more than $900 per recipient per calendar month must be preauthorized. |

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| PROGRAM | LIMITATIONS |
|---|---|
| 8. Private duty nursing services | Private duty nursing services are provided only as Enriched Home-Visiting Services through the Healthy Start Program. The services are provided by registered nurses licensed in the jurisdiction in which services are provided. |

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| PROGRAM | LIMITATIONS |
|---|---|
| 9. Clinic Services<br><br>a. Free-Standing Clinic | 1. Clinics must be under the direction of a physician or dentist.<br><br>2. All providers in free-standing clinics must have written agreements with the Program.<br><br>3. Billing time limitations:<br><br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.<br><br>c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.<br><br>d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. |

See Page 9-2

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| PROGRAM | LIMITATIONS |
|---|---|
| | 4. All clinics are subject to the limitations explained in Attachment 3.1A of the State Plan. |

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| PROGRAM | LIMITATIONS |
|---|---|
| 9. Clinic Services<br><br>b. Medical Day Care Services | 1. Services to recipients who are not elderly or medically handicapped adults in accordance with Article 43, sections 717A-717J of the Annotated Code of Maryland.<br><br>2. Services to recipients who are not PSRO certified as needing skilled nursing facilities service or intermediate care nursing facilities service.<br><br>3. Services not authorized on a plan of care by a licensed physician.<br><br>4. Speech therapy services.<br><br>5. Services for which payment is made directly to a provider other than a medical day care facility.<br><br>6. Billing time limitations:<br><br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.<br><br>c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. |

See Page 9-2

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| PROGRAM | LIMITATIONS |
|---|---|
| See Page 1-2 | e. Claims submitted after the time limitations specified in (a)-(d) above because of a retroactive eligibility determination will be considered for payment if received by the Program within 6 months of the date on which eligibility was determined, or within the original 1 year period, whichever is later. |

TN_____ Approval date_____

Supercedes TN_____ Effective date SEP 1 1984

STATE PLAN FOR MEDICAL ASSISTANCE
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83-16

| Program | Limitations |
|---|---|
| 10. Dental Services | A. The Program places the following limitations upon covered services:<br><br>1. Reimbursement for a complete radiographic survey or full series of X-rays of the mouth may not be made more frequently than once every three years to the same provider, or in the case of a group practice, to any partner or associate of the practice, unless specifically required or requested by the Program.<br><br>2. For any traumatic injury case, a provider may be reimbursed for a maximum of four pancramic radiographs. When services are rendered by members of a group practice or association, reimbursement to the group practice or association shall also be limited to a maximum of four panoramic radiographs.<br><br>3. Root canals and pulpectomies may not be covered when:<br><br>a. Root resorption has started and exfoliation is imminent;<br><br>b. Gross periapical or periodontal pathosis is demonstrated on the radiograph; or<br><br>c. The general oral condition does not justify root canal therapy.<br><br>4. Reimbursement for crowns will be limited to permanent acrylic fused to metal crowns, permanent porcelain fused to metal crowns, permanent nonprecious metal (full cast), temporary acrylic crowns. and stainless steel crowns.<br><br>5. Plastic and composite resotrations will be covered only for the six anterior teeth in each arch.<br><br>6. Replacement dentures for EPSDT participants, or for recipients who meet the requirements of COMAR 10.09. 05.04A(3) are covered only when:<br><br>a. Dentures have been lost, broken or stolen, after one year of placement; or<br><br>b. Adjustment, repair, relining, or rebasing of the patient's present denture does not make it serviceable.<br><br>7. Rebasing is included in the six months of aftercare following denture placement, and may not be provided more frequently than once every two years after that. |